### Kansas Department for Aging and Disability Services Workforce Enhancement in Nursing Facilities - Special Project Invoice-Summary

Grant #:							
Grantee Name:				Grant Period:	From	to	
Title of Course / Training Activity:				Billing period:	From	to	
			Number of Indi	viduals trained this invoice period:			
	Unlicensed Staff	Licensed Staff	Total Staff	Unduplicated total # of facilities with employees attending training activity billed on this invoice	Total Amount Billed		
ATTACH FORM KDOA 336a, Workforce Enhancement in Nursing Facilities - Special Project - Detail Invoice							
I hereby certify:  1) The amount invoiced is for training of unlicensed staff currently employed by either a certified and licensed long-term care nursing facility (nursing home) or a long-term care unit of a hospital. No individuals employed in freestanding or attached Assisted Living Facilities, Residential Health Care Facilities, Home Plus Facilities, Boarding Homes, Home Health Agencies, Hospices, Hospitals and Hospital Swing Bed Units are included in this invoice.							
2) To the best of my knowledge all training activities billed herein are in accordance with the Workforce Enhancement in Nursing Facilities, request for proposal, my agency's grant application and Notification of Grant award.							
Authorized Official Name & Title:  Authorized Official Name & Title:							
(Please type or print Name & Title)							
Signature of Authorized Certifying Official:					Phone:		
Contact Person:							

Page 1 of 1 Form KDOA 336 11/05

#### Kansas Department for Aging and Disability Services Workforce Enhancement in Nursing Facilities - Special Project Invoice-Detail

Grant #:	
Grantee:	Presented by:
Title of Course/Training Activity:	Date of Session:
Name/Locaion of Facility:	
Name/Address of Presentation:	

						CHECK		 
	Trainee/ Attendee	Position Title *(no abbreviations)	Certificate Number	License Number	Employer	Employe Nursing Facility	041	employed in LTC
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

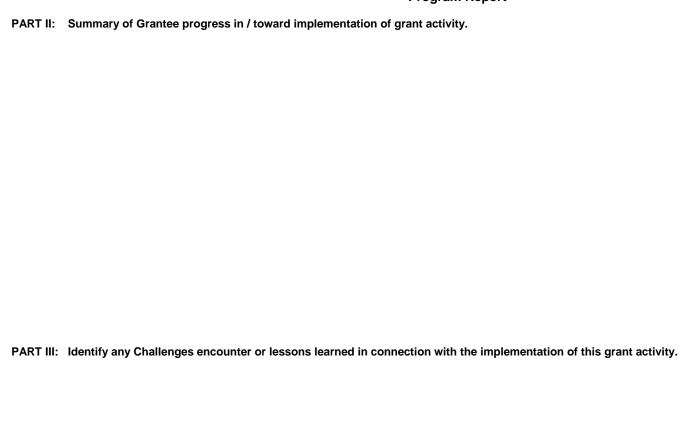
<sup>\*</sup>May use Rn, LPN, CNA, CMA, SSD, AD. All other individuals needs to write out their position title.

# Kansas Department for Aging and Disability Services Workforce Enhancement in Nursing Facilities - Special Project Program Report

Grant #:				
Grantee:				_
Γitle of Course/Tra	ining Activity:			
Report Period:	From	То		
PARTI: Numb	per of Eligible Individuals	Trained by Employer		
#	f of Individuals Trained		Employer	
1				
2				
3				
4				
7				
8				
10		<del></del>		

0

## Kansas Department for Aging and Disability Services Workforce Enhancement in Nursing Facilities - Special Project Program Report



Form KDOA 336b 11/05 Page 2 of 3

## Kansas Department for Aging and Disability Services Workforce Enhancement in Nursing Facilities - Special Project Program Report

PART IV: Summarize Actions taken to overcome challenges encountered in implementation of grant activity.

PART V: Summary of recommendations.

Form KDOA 336b 11/05 Page 3 of 3